FIRST INTERIM REPORT

of the

SPECIAL SENATE COMMITTEE

to study the

IMPACT OF DEINSTITUTIONALIZATION

on the

CARE, QUALITY AND MANAGEMENT

of the

MENTAL HEALTH AND RETARDATION SERVICES

in the

COMMONWEALTH OF MASSACHUSETTS

Senator Arthur J. Lewis Jr., *Chairman*
Senator Daniel J. Foley
Senator Mary L. Padula

FIRST INTERIM REPORT OF THE SPECIAL SENATE COMMITTEE TO STUDY THE IMPACT OF DEINSTITUTIONALIZATION ON THE CARE, QUALITY AND MANAGEMENT OF THE MENTAL HEALTH AND RETARDATION SERVICES IN THE COMMONWEALTH OF MASSACHUSETTS

[Senate, April 20, 1983 — Offered by Senator Arthur Joseph Lewis, Jr.]

SENATE . . . . . No. 1914

The Commonwealth of Massachusetts

SENATE, April 20, 1983.

Ordered, That a special committee, to consist of three members of the Senate, one of whom shall be a member of the minority party is hereby established to investigate and study the impact of deinstitutionalization on the care, quality and management of the mental health and retardation services in the commonwealth.

Said investigation shall include but not be limited to procedures for voluntary and involuntary commitment, contracting and budgeting practices, the effectiveness of public and private mental health programs and facilities, the department of mental health procedures to ensure adherence to existing law and regulations, and the type of accommodations available to deinstitutionalized patients, with particular emphasis on safety, medical care, supervision and habitability.

ACKNOWLEDGEMENT

The Special Senate Committee wishes to thank all of the individuals from the mental health community and the public at large that contributed to the Committee's work, either by offering testimony, supplying specific information or by commenting on the committee's work.

The Committee would especially like to thank Alfred F. DeSimone of the Department of Correction, Dr. Robert Fein of the McLean/Bridgewater program at MCI Bridgewater, Dr. Loren Schector of the psychiatric program at MCI Framingham and the other correction officials that provided testimony and statistics.

The Committee also thanks Ann Hargreaves, Emily Chandler, Sandra Austin and Dr. Albert Feingold of Boston City Hospital.

The Committee would also like to extend its appreciation to John Vogelgesang of the Mental Health Advisory for the South Norfolk Area, James Derba of the former Governor's Commission on Mental Health Facilities, and the many others that testified before the committee, including William Powers, John Sullivan and Richard Krant who each have retarded children within the state school system.

In addition, the Committee would like to thank Mental Health Commissioner James J. Callahan, Jr., and Martha Dunn of the department for their assistance and cooperation.

The Committee would also like to acknowledge the many family members of mentally ill and retarded individuals who took the time to write the committee in offering suggestions and explaining their experiences in dealing with deinstitutionalization.

This report is submitted to the Clerk of the Senate in accordance with Senate Order No. 1914 on this day of , 1984.

COMMITTEE MEMBERS

Senator Arthur Joseph Lewis, Jr. _____

Senator Daniel J. Foley _____

Senator Mary L. Padula _____

BACKGROUND

The seeds of the community based deinstitutionalization program were planted by the passage of the federal Community Mental Health Center Act in 1963.

Masachusetts subsequently created the Mental Health Planning Project which released a 1965 report entitled *Mental Health in Massachusetts*.

That report called for the creation of a community service network and reduction in the use of state hospitals to treat the mentally ill.

The legislature responded in 1966 with the adoption of Chapter 735 and again in 1970 with the passage of Chapter 123.

Those two acts together gave birth to the state's program of deinstitutionalization and formed the basis of the Commonwealth's public mental health system as currently designed.

Since that time Massachusetts has implemented the deinstitutionalization program aggressively.

The state has decreased its state hospital census from approximately 22,000 patients to the current approximate daily census of 2,000.

The rapid decrease in the number of mentally ill patients being treated in Massachusetts state hospitals has been completed at a rate approximately five times that of New York, which reduced its in-patient state hospital census from approximately 70,000 in 1955 to some 20,000 today.

The current average daily census in the Commonwealth is expected to remain stable at approximately 2,000 individuals, according to Department of Mental Health Commissioner James J. Callahan, Jr.

The commissioner testified before the committee that the exodus from the state hospitals has been completed.

The motivation and theory behind the deinstitutionalization program both in the Commonwealth and throughout the country was:

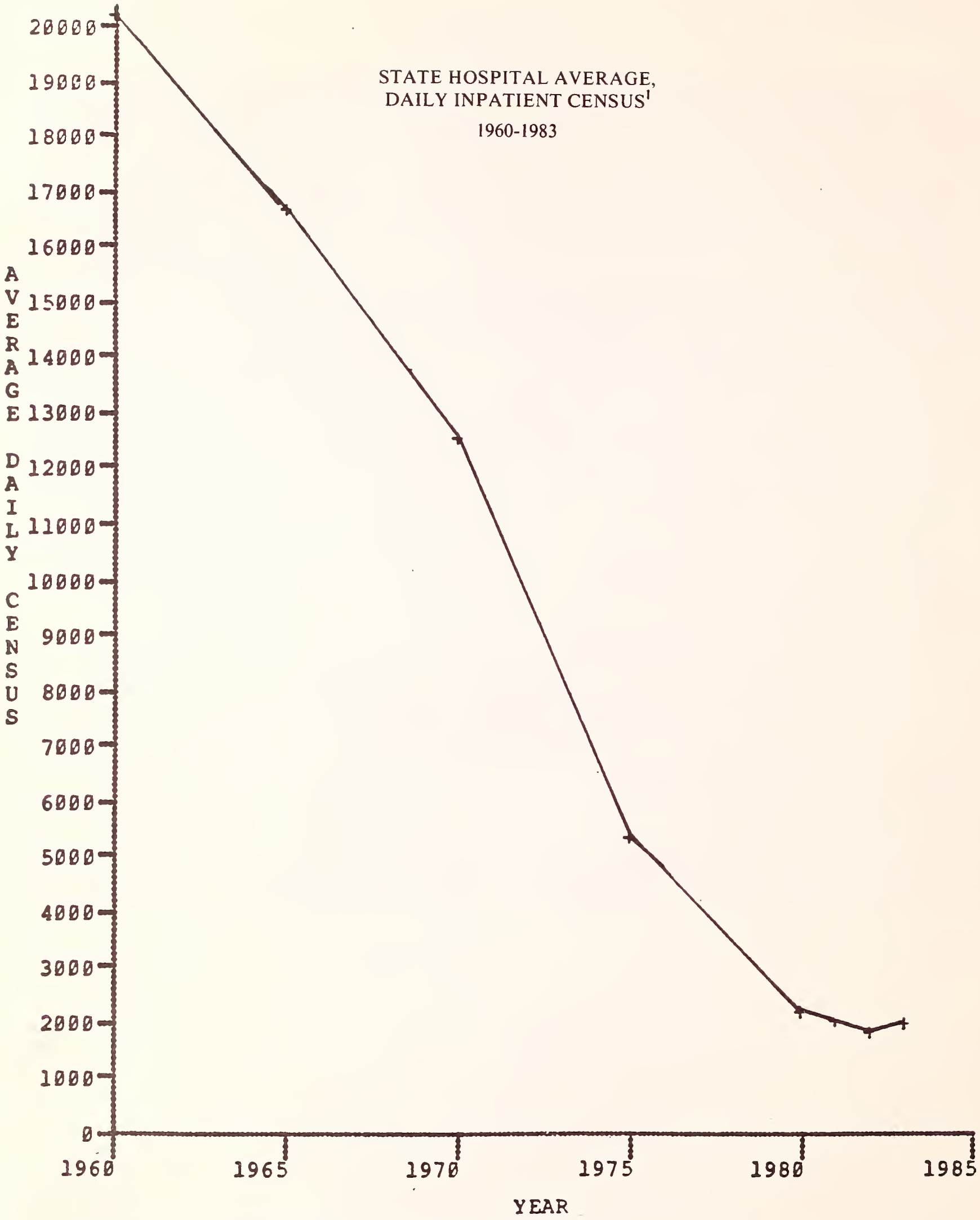
1) To provide better treatment for individuals in a setting closer to their home communities.
2) To provide treatment in the least restrictive alternative.
3) To decrease and control the costs of running the civil-service dominated mental health system.
4) To increase the amount of federal dollars obtained for mental health services at a time when the federal government was advocating a community based system of treatment.
5) To create a mental health care system in which the majority of direct care would be offered by private vendors working through state contracts.

With the theory in place, DMH reduced its in-hospital census from 22,000 in 1955 to 17,000 in 1967 and finally to the current 2,000.

The in-hospital population is serviced by seven state hospitals: Northampton State Hospital, Worcester State Hospital, Westborough State Hospital, Danvers State Hospital, Taunton State Hospital, Medfield State Hospital and Metropolitan State Hospital.

STATE HOSPITAL AVERAGE,
DAILY INPATIENT CENSUS[1]

1960-1983



Source: Department of Mental Health
Year: 1983

[1]State hospitals do not have a set bed complement; figures are based on average daily census.

AVERAGE DAILY CENSUS
OF CATCHMENT AREA UNITS WITHIN STATE HOSPITALS AND MENTAL HEALTH CENTERS
FOR THE PAST 13 MONTHS

	MAY 83	JUN 83	JUL 83	AUG 83	SEP 83	OCT 83	NOV 83	DEC 83	JAN 84	FEB 84	MAR 84	APR 84	MAY 84
REGION I													
NORTHAMPTON STATE HOSPITAL													
BERKSHIRE	40	41	42	39	41	41	39	35	34	38	37	36	33
FRANKLIN-HAMPSHIRE	68	72	75	74	67	63	59	61	58	59	56	53	56
HOLYOKE-CHICOPEE	36	38	39	42	40	40	37	36	37	39	36	39	37
SPRINGFIELD	89	93	98	92	87	89	87	83	83	89	84	86	89
WESTFIELD	20	21	25	26	22	17	16	14	12	11	13	21	23
TOT NORTHAMPTON STATE HOSPITAL	253	265	278	273	256	250	238	229	224	235	226	235	237
REGION II													
WORCESTER STATE HOSPITAL													
BLACKSTONE VALLEY	45	44	44	48	49	51	50	48	47	48	51	51	50
GERIATRIC	81	84	82	82	83	85	87	83	86	88	86	86	86
GREATER WORCESTER	107	118	116	115	115	128	131	128	136	135	129	131	134
MEDICAL	10	8	6	11	10	7	8	9	8	8	9	11	11
MENTAL RETARDATION UNIT	32	32	32	32	32	32	32	31	31	31	31	32	33
NORTH CENTRAL MASS.	82	82	79	82	91	90	87	83	90	89	93	86	88
SOUTH CENTRAL MASS.	40	36	38	38	39	42	43	40	41	44	42	40	45
TOT WORCESTER STATE HOSPITAL	397	405	398	408	420	435	438	422	438	443	442	437	447
REGION III													
CENTERPOINT DSH													
ADOLESCENT UNIT	12	12	12	11	11	11	12	12	12	12	12	12	12
DANVERS STATE HOSPITAL													
CAPE ANN	24	22	20	18	22	25	23	22	26	22	22	22	21
DANVERS-SALEM	46	46	48	48	50	50	47	49	49	52	50	48	49
EASTERN MIDDLESEX	19	21	20	19	19	20	20	20	17	18	21	22	19
HAVERHILL-NEWBURYPORT	49	44	45	44	43	44	45	44	45	45	48	49	47
LAWRENCE	38	41	46	47	43	43	41	38	41	44	49	50	49
LYNN	27	25	28	31	35	34	30	31	32	31	32	33	29
TOT DANVERS STATE HOSPITAL	204	199	207	206	213	216	206	203	209	210	222	224	214
H.C.SOLOMON													
MENTAL HEALTH CENTER	47	44	45	45	45	47	45	46	46	44	45	44	45
REGION IVA													
GAEBLER													
CHILDRENS CENTER	47	45	44	41	40	48	45	46	49	50	48	54	53

AVERAGE DAILY CENSUS
OF CATCHMENT AREA UNITS WITHIN STATE HOSPITALS AND MENTAL HEALTH CENTERS
FOR THE PAST 13 MONTHS

	MAY 83	JUN 83	JUL 83	AUG 83	SEP 83	OCT 83	NOV 83	DEC 83	JAN 84	FEB 84	MAR 84	APR 84	MAY 84
METROPOLITAN STATE HOSPITAL													
CAMB-SOMER	97	98	102	102	105	103	106	104	105	102	107	107	112
CONCORD	39	38	39	38	40	42	41	42	43	38	38	41	42
GERIATRIC	39	36	29	22	16	3	0	0	0	0	0	0	0
METROPOLITAN-BEAVERBROOK	92	93	85	87	86	90	91	94	92	94	89	94	94
MYSTIC VALLEY	58	55	55	59	62	59	60	58	60	57	61	62	63
TRI-CITY	47	47	46	47	52	49	48	53	56	54	52	50	50
TOT METROPOLITAN STATE HOSPITAL	373	367	357	354	362	346	346	351	356	345	347	354	361
REGION IVB													
CUSHING HOSPITAL													
CUSHING HOSPITAL	380	385	387	387	389	384	384	385	383	381	379	376	379
MEDFIELD STATE HOSPITAL													
COASTAL	62	61	54	58	57	55	61	60	59	61	58	64	63
NEWTON-WELLESLEY-WESTON	67	69	67	69	73	67	67	68	71	73	70	69	72
SOUTH NORFOLK	67	75	67	69	71	69	65	66	71	72	71	71	68
SOUTH SHORE	68	64	59	63	65	71	67	69	73	74	75	76	69
TOT MEDFIELD STATE HOSPITAL	263	270	247	259	266	262	260	263	274	280	273	280	272
WESTBOROUGH STATE HOSPITAL													
HADLEY SPECIAL TRTMT	129	133	133	135	136	148	151	145	153	153	155	153	151
SOUTH MIDDLESEX	61	62	65	60	56	56	50	61	70	71	68	68	73
WESTBOROUGH-MARLBORO	30	33	31	32	31	37	37	41	38	39	35	37	35
TOT WESTBOROUGH STATE HOSPITAL	220	227	229	227	223	241	238	247	260	263	258	258	259
REGION V													
BRIDGEWATER													
TREATMENT CENTER	206	206	208	207	205	206	210	213	213	215	218	222	227
CAPE COD & ISLANDS													
POCASSET MENTAL HEALTH CTR	22	18	22	23	19	18	16	13	20	18	19	21	17
FALL RIVER													
CORRIGAN MENTAL HEALTH CTR	36	31	28	28	30	33	32	33	36	38	36	35	34
TAUNTON STATE HOSPITAL													
BROCKTON	63	68	64	66	60	60	60	58	60	60	60	60	56
NEW BEDFORD	102	105	100	104	107	107	106	105	105	103	101	90	90
P.A.T.	101	109	113	106	118	117	114	112	111	109	105	105	107
TOT TAUNTON STATE HOSPITAL	266	282	276	276	284	284	280	275	276	272	266	256	253

AVERAGE DAILY CENSUS
OF CATCHMENT AREA UNITS WITHIN STATE HOSPITALS AND MENTAL HEALTH CENTERS
FOR THE PAST 13 MONTHS

	MAY 83	JUN 83	JUL 83	AUG 83	SEP 83	OCT 83	NOV 83	DEC 83	JAN 84	FEB 84	MAR 84	APR 84	MAY 84
REGION VI													
DORCHESTER MENTAL HEALTH CENTER	42	49	51	48	49	43	43	47	49	51	49	50	50
LINDEMANN MENTAL HEALTH CENTER	54	47	48	53	53	50	51	50	48	51	53	54	55
MASSACHUSETTS MENTAL HEALTH CENTER	43	42	43	40	43	42	40	44	46	41	42	45	45
S.C.FULLER MENTAL HEALTH CENTER	69	65	64	68	65	70	71	78	77	65	68	71	68
TUFTS - BAY COVE MENTAL HEALTH CENTER	68	68	67	67	72	69	67	69	74	71	62	61	59
WES-ROS-PARK MENTAL HEALTH CENTER	12	15	13	12	12	11	11	13	15	15	12	14	14
TOT FOR STATE HOSPITALS	1978	2016	1992	2004	2025	2035	2006	1990	2037	2048	2035	2043	2043
TOT FOR MENTAL HEALTH CTRS	393	380	379	385	389	383	378	392	412	395	388	396	386
TOT FOR CHILDREN CENTERS	47	45	44	41	40	48	45	46	49	50	48	54	53
TOT FOR ADOLESCENT CENTERS	12	12	12	11	11	11	12	12	12	12	12	12	12
TOT FOR ELDERLY-CUSHING	380	385	387	387	389	384	384	385	383	381	379	376	379
TOT FOR BRIDGEWATER TREATMENT CTR	206	206	208	207	205	206	210	213	213	215	218	222	227
OVERALL TOTAL	3016	3044	3022	3035	3059	3068	3034	3038	3106	3101	3079	3102	3100

EXECUTIVE SUMMARY

The Special Senate Committee to Investigate and Study the Impact of Deinstitutionalization on the Care, Quality and Management of the Mental Health and Retardation Services in the Commonwealth was established by Senate Order 1914 on April 20, 1983.

The membership of the Special Committee is as follows: Senator Arthur J. Lewis, Jr., of Suffolk and Norfolk, Chairman, Senator Daniel J. Foley of First Worcester and Middlesex, and Senator Mary L. Padula of Second Worcester and Middlesex.

Consistent with the mandate given the committee, it strived to determine the effect of the program on the mentally ill and mentally retarded citizens that deinstitutionalization was designed to benefit.

Public hearings, private meetings and general research was used to gather as much pertinent data as possible.

The record shows that if it were not for the deinstitutionalization program, at least 11 patients would not have fallen victim to two rooming house fires.

The Worcester and Beverly rooming house fires are only two of the more dramatic, tragic stories that have come about as a result of the program.

Throughout its investigation the committee uncovered numerous less dramatic but nonetheless tragic tales of deinstitutionalization attempts gone sour.

This committee believes that while there is a segment of the mentally ill and retarded population that can and does adjust well to deinstitutionalization and placement in the community, there is also a large segment that has not been able to make the adjustment successfully.

It is this latter group which the Department of Mental Health has so greatly failed.

Testimony taken during public hearings on the program indicated the prevalent feeling among a large segment of those who have dealt with deinstitutionalization, on both a personal and professional level, is that it was ill-conceived, poorly planned and badly implemented.

The end result is an ever increasing dependence on the private, profit-minded, business world to care for the Commonwealth's mentally retarded and mentally ill citizens.

While the business world turns a profit, many mentally ill and retarded citizens find themselves living in group homes located in neighborhoods where the residents do not want them.

It is the belief of the committee, that in these situations where patients are shunned by the community, the program has created the exact type of setting it was designed to dissolve.

In these types of situations, the deinstitutionalized are in effect secluded in a home that happens to be in a residential neighborhood.

The new and smaller setting lacks the vital psychiatric support that the state hospitals once offered.

In some cases it can result in threatening confrontations between the patients and individuals within the community, who in some cases lash out in violence against the deinstitutionalized.

Those living in unwanted group homes may be the lucky ones unfortunately.

For numerous reasons many deinstitutionalized patients end up among the ranks of the homeless where they may go for days simply wandering the streets without food or shelter.

The injustice of the program is that many mentally disturbed and retarded citizens — many of whom virtually grew up in the state hospitals and feel comfortable with the routine that it offered — are ending up in the ranks of the homeless, in prison cells, in hospital emergency wards, and in community homes where neighbors shun their existence.

The growing tragedy of the program is evident in every city across the state.

One need only take a stroll through the downtown areas of Boston, Worcester, Springfield or other urban centers to see many of the state's deinstitutionalized patients and the havoc the program has brought on their lives.

Many have resorted to begging in the streets as a means of survival. They walk the streets day and night in tattered clothing and are susceptible to becoming victims of serious crimes.

The Committee believes the state has a solemn duty to take care of those who are incapable of taking care of themselves in a proper manner, and make sure that business interests do not look upon them as a means to make money.

TEXT

On April 19, 1983 disaster struck a Worcester community home housing deinstitutionalized patients formerly cared for at Worcester State Hospital.

The 2 a.m. fire at Central Community Home killed seven of the 23 registered at the home. Of the 23, 21 were former Worcester State Hospital patients.

An investigation of the fire by the National Fire Protection Association determined there were 20 occupants sleeping on the first, second and third floors of the building when the fire occurred. There was no staff person at the house.

The NFPA found that a second floor occupant who discovered the fire under his bed unsuccessfully tried to extinquish the blaze and then dragged or carried the mattress along the floor to the bathroom where it flared into a full-flaming condition. The occupant then ran out of the building.

The fire alarm or smoke detection system sounded and most of the occupants escaped unassisted, using the front stairway. The fire then spread rapidly throughout the second floor creating untenable conditions on the second and third floors, including the stairways, the NFPA found.

Worcester firefighters, using self-contained breathing apparatus, found four of the victims in two rooms, one of whom was located in a closet. Two other victims were found on the second floor and the seventh died as the result of jumping from a third floor window.

The Worcester County District Attorney's office, the State Fire Marshal, the Worcester Fire Department and National Fire Protection Association all agreed that the fire was caused by the careless disposal of smoking material.

It is difficult to judge ahead of time how any individual would react to an early morning fire that rouses one from sleep and immediately demands rapid and rational reasoning in order to escape its clutches.

It is decisively more difficult to judge how an individual suffering any form of mental illness will react under those circumstances.

The July 4th, 1984 Beverly rooming house blaze in which four other deinstitutionalized patients perished along with 10 others — many of whom were described as 'down and outers' — points to the numerous problems deinstitutionalized patients face in their daily lives.

Food and shelter, the basic means of existence which are taken for granted by most, can and does become an all encompassing search for many deinstitutionalized patients.

Deinstitutionalized patients' earning powers are severely hampered, with many unable to earn more than minimum wage, and some less.

In addition, the availability of low-cost housing has experienced a steady decline over the past decade.

Fire officials throughout the state have voiced a growing concern that deinstitutionalized patients, who are less able to react to an emergency situation, are ending up in older, more fire-prone buildings.

The combination of low earning power, the increasing cost of rental units and the decreasing availability of rental units is forcing many deinstitutionalized patients to find shelter in rooming houses which are virtually match boxes waiting to be ignited.

Low cost rooms tend to be located in urban centers where older buildings meet only minimal standards for safety.

The Beverly rooming house fire is an example of a turn of the century building that met the minimum standards required by law, but which lacked fire walls and fire stops.

Beverly Fire Chief Dean Palmer was quoted as saying the rooming house "was built to burn."

One of the realities of the well intentioned deinstitutionalization program has been the reshuffling of patients from the care of trained state mental hospital staffers to understaffed private and public hospital emergency rooms and homeless shelters who are ill-prepared to deal with the mentally disturbed patient.

One example is the overwhelming increase in the number of mentally disturbed patients Boston City Hospital is asked to care for through its emergency room service.

Professional health care specialists at the hospital testified that of the 300 new patients the emergency room treats every month, approximately 270 are people with psychiatric disorders.

Further examination of the emergency room's problems show that of the 270, approximately 50 will need to see a psychiatrist and 200 will be found to have at some point in time been under the care of the Department of Mental Health and subsequently deinstitutionalized.

In fact, the second highest diagnostic category of all patients who walk into Boston City Hospital's emergency room is a primary psychiatric problem, according to the staff.

Through this and other examples the committee has found that the exodus from the state mental hospitals has put more pressure on private hospitals to accept these individuals.

While the private hospitals may accept those it believes are treatable, it is the untreatable patient who is more likely to be found wandering the streets, looking for emergency wards and living in cramped rooming house quarters.

Hospitals geared toward the treatment of physical disorders, which then find mentally disturbed patients entering its doors, are faced with the dual problem of not having the resources to treat mentally ill patients as well as being unable to turn to the state to find treatment for the patient.

Hospital staffers are then saddled with the increasingly difficult task of finding appropriate care for these people.

The coordinator of discharge planning at Boston City Hospital testified before the committee that patients have remained at the hospital for as long as two years while the staff tried unsuccessfully to find appropriate care for them at private institutions or nursing homes.

The impact on the hospital has been the forced addition of 12 psychiatric nurses to deal with the problem without any reimbursement by the state.

The impact on the patients who are now forced to turn to Boston City Hospital for help is that the hospital is attempting to treat them while lacking a multitude of clinical, physical and referral services necessary to effectively deal with the patients' needs.

The hospital has no psychiatric ward and therefore must treat the patients in a routine setting designed for patients with physical rather than mental illness.

As a result, not only are the mentally ill patients not receiving treatment under the best possible conditions, but those who are at the hospital with physical ailments are also forced to deal with sometimes stressful situations involving mentally ill patients.

Hospital psychiatric staffers believe that mounting evidence indicates there is a growing group of chronic young adult patients in the community who have had little, if any, hospital care. The young adults and children are beginning to show up in increasing numbers and display social problems which would have been more easily treated at an early stage through a well structured state mental hospital system.

A special Senate report released in June of this year by the Special Senate Committee On Mental Health supports that evidence.

The committee found that "hundreds of children are living on adult wards of the state's mental hospitals and few programs exist for the intensely disturbed children."

While hospitals are attempting to deal with the increasing numbers of deinstitutionalized patients that make their way through the emergency rooms, shelters for the homeless are experiencing drastic changes in the background of those seeking protection from the elements and a warm meal at the homes.

At the Pine Street Inn in Boston, staff personnel have watched the prevalent group over the past decade change from one in which the majority were coping with alcohol abuse problems to a group whose main disadvantage is mental illness.

The committee's discussion with those who operate shelters indicate that DMH's movement to turn people out of the mental health system has made it increasingly more difficult for shelters and referral centers to gain access to mental health services for their clients.

As one official from Pine Street Inn put it at a public hearing: "There seems to be an increasing trend to encourage people to leave the mental health system as opposed to providing services, and that has caused problems for us."

A report compiled by the Massachusetts Association for Mental Health and the United Community Planning Corporation in 1983 indicated that 90 percent of those found at the Lemuel Shattuck Shelter on a given night have a diagnosable mental illness.

The group of five psychiatrists, two psychologists, and two social workers interviewed 78 guests at the shelter.

The study, conducted at the Shattuck because it was considered to be demographically representative of Boston-area shelters, concluded that 44 percent of the 78 guests also had major medical disorders including heart disease, high blood pressure, ulcers, emphysema, asthma and severe cellulitis.

Of the group, only 55 percent reported that they had received appropriate medical care and many had difficulty following medical instructions or keeping follow-up appointments.

Forty percent were diagnosed to be suffering from some form of psychosis (a difficulty in distinguishing external reality from their own thoughts and feelings). Of this group, 23 were diagnosed as schizophrenic, 4 manic-depressive and 3 depressive.

Of the entire sample, one-third had been previously hospitalized for psychiatric reasons, 13 percent had been hospitalized more than once, indicating a substantial percentage were deinstitutionalized.

The report went on to conclude that "of the 30 psychotic patients, only 4 were on anti-psychotic medications, only 4 guests were currently in supportive psychotherapy, and 3 in aftercare."

Another 21 percent of those at the shelter were diagnosed to have personality or character disorders creating major difficulties in forming and maintaining relationships, and holding steady jobs.

Another 29 percent were chronic alcoholics, of which five also had a secondary diagnosis of psychoses.

Other statistics reported from the survey show: 39 percent reported having been in jail, one-third for dangerous crimes, and 74 percent were unemployed.

Possibly the most tragic injustice that deinstitutionalization has created is the resulting numbers of deinstitutionalized patients who have ended up in prison cells, either briefly or permanently, since their release.

Changes in admission at Bridgewater State Hospital, the state's only maximum security psychiatric facility, have been dramatic as the result of deinstitutionalization.

In 1972 the total number of admissions at Bridgewater numbered 575. Over the past five years that number has increased to more than 1,000 admissions each year, with more than 1,100 admitted in 1982 and again in 1983.

While the Department of Correction was unable to provide statistics on the number of deinstitutionalized patients admitted to Bridgewater after being charged with crimes, it did report a dramatic increase in the number of former mental health patients over the past five years.

Correction officials reported that Bridgewater is being asked to take in increasing numbers of men who have gone to the Department of Mental Health asking for admission, been told they did not qualify for admission and subsequently gone out, committed minor crimes, and been sent to Bridgewater by the court system.

Corrections lists some 100 patients at Bridgewater who have been sentenced to the facility because they were either incompetent to stand trial or found not guilty of a crime by reason of insanity.

Bridgewater officials testified that these individuals do not necessarily need the strict security of Bridgewater but do need long term custodial care.

One example of such a patient is a man who in 1976 killed someone he believed was the devil. After being found not guilty by reason of insanity, he was sentenced to Bridgewater State Hospital where the staff reports he has not been involved in one violent incident since, but remains disturbed and is likely to continue to be so.

Dr. Robert Fein of McLean Hospital, who is under contract to provide psychiatric services at Bridgewater, testified that the patient discribed above and numerous others at the maximum security facility need long term care. Fein noted that these individuals do not belong in the community, but also do not need the maximum security of Bridgewater.

With the options limited to either the street or the state's maximum security psychiatric facility, the patients and society are best protected by keeping the patients at Bridgewater.

In addition to Bridgewater experiencing a dramatic increase in the number of disturbed patients it receives through the court system, it has also experienced a doubling in the number of patients DMH has sent to it as unmanageably violent in a DMH facility.

In 1982 DMH sent 83 such patients to Bridgewater.

One of those patients termed "unmanageable" by DMH and sent to Bridgewater was a double amputee (meaning no arms or legs).

With the large numbers of patients being treated by the Department of Correction and the low Department of Mental Health state hospital census, the evidence suggests that Correction is providing some 25 percent of all the state funded in-patient mental health care.

In a 1983 paper authored by Dr. Fein entitled *Changes In The Evaluation And Care Of Male Mentally Disordered "Offenders" In Massachusetts*, he uses several real life stories of mentally ill and retarded citizens to demonstrate how the mental health care system has changed.

Case #1: In 1977 a 62-year-old man was sent from a DMH hospital for his first admission to Bridgewater. The patient, formerly a boxer, had been hospitalized continually since 1939. Reports suggested that he had lived in a seclusion room at one state hospital for approximately 20 years. When that state hospital was closed he was transferred to another and later to a third after the second one was also closed. In the third hospital, the stocky man, who never spoke, was placed in a chronic care unit.

He showed signs of being disturbed by changes in his environment and when the unit was noisy he appeared restless and agitated. In 1975 the chronic care unit was closed and he was again shifted, this time to an acute care unit where the noise level was much higher. The man became assaultive, reverting to a fighting behavior when he felt threatened or upset. He continued to remain speechless and finally in 1977 was transferred to Bridgewater State Hospital after the unit director at the acute care ward determined he could no longer be cared for.

The patient remains at Bridgewater where he spends most of his time lying in bed. Every effort to have him transferred back to a DMH facility has met with "impassioned testimony that 'we no longer have the capability to handle patients like that.'"

Case #2: A 29-year-old mildly retarded and occasionally psychotic man was discharged from years of state mental hospitalization to a half-way house.

The man had spent many years in state schools for the retarded and in mental hospitals. A man with no family, he was seen as a patient on the fringe of the institution, working in the hospital laundry room, receiving three meals a day and a place to sleep. Occasionally he would leave the hospital, get drunk and the police would escort him back.

The patient was unsure whether he wanted to go to the halfway house and shortly after arriving there he went out drinking, violating the rules of the house including the curfew.

He was reprimanded and the next night he went to a local motel where he threatened the clerk with a knife saying he wanted money. The clerk, sensing that the patient was not experienced in robbery, said the money was in the back room and went in there to get it closing the door behind him.

When the police arrived 10 minutes later, the patient, still standing with knife in hand awaiting the clerk's return, was arrested and sent to jail to await trial. He became psychotic, set a fire in his cell and was transferred to Bridgewater for 30 days of observation, and then returned to jail.

He decompensated again and was returned to Bridgewater. Because of his retardation there was a question of whether or not he was competent to stand trial on the armed robbery charges. Ultimately the charges were dropped and after the staff of the state hospital argued that he was too dangerous for their facility, he was committed to Bridgewater. The staff at Bridgewater worked with him for two years and a plan was developed which ultimately resulted in his discharge to a half-way house for retarded offenders.

While there has been a dramatic increase in the number of men sent to Bridgewater by DMH and the court system, transfers from county jails and houses of correction have also increased since the implementation of deinstitutionalization.

Transfers from jails and houses of correction jumped from 138 men in 1975 to 336 in 1982 and to 467 in 1983. The change occurred at a time when transfers from the state prison system remained constant.

The increasing dependence on Bridgewater to care for these types of individuals has dramatically increased the daily census at the facility.

While the safe management level at Bridgewater stands at 311 patients, the facility is averaging more than 450 on a daily basis.

In all, some 1165 patients were sent to Bridgewater in 1983. Of the 460 patients at Bridgewater as of this writing, the Department of Correction reported it believed 125 would be better served in a state custodial setting if such a place existed.

Inappropriate incarcerations of mentally ill and mentally retarded citizens have not been limited to men sent to MCI Bridgewater.

The state's only prison for women creates additional and unique problems for women in similar situations.

Because the state has only one facility for women there is a complete mix at MCI Framingham which is saddled with dealing with both mentally ill individuals convicted of crimes, drunk drivers, murderers and everything in between.

Correction officials testified that both the maximum security unit and the prison hospital unit generally have between 30 and 50 percent occupancy by women who are mentally ill.

The hospital unit at the facility is ill equipped to deal with a wide variety of sickness, both mental and physical. While medical doctors are on call there are none stationed at the unit. The prison therefore often depends on outside medical facilities to help care for the physically ill.

The only alternative to obtain help for the mentally ill however is to petition the court for admission to a state hospital for up to 30 days.

Some of the examples given by Correction officials of women incarcerated at MCI Framingham with mental problems in 1983 include:

1. A 24 year old, brain damaged, mentally retarded woman with Cerebral Palsy was sentenced to 90 days at MCI — Framingham for assaulting a security officer at a state hospital. The officer was allegedly trying to remove her from the grounds of the state hospital, to which she wanted to return. This woman has not been successful in adjusting to DMH sponsored community residences and has sometimes run away from the state hospital. Because of her physical handicaps in speech and intellect, she cannot be integrated into the prison population. She is housed on the Health Services Unit of the prison, where she has twice attempted suicide, once by hanging and once by ingesting an iodine solution used to disinfect bedpans.

2. This 34 year old woman strips herself naked, smears herself and the walls with feces and urine, masturbates openly and actually eats her feces. She has a 17 year history of frequent mental hospitalizations, but her community mental health center no longer considers her psychotic and will not admit her as an inpatient for more than two or three days because she is so disruptive and regresses to infantile levels when confined. Unfortunately, this woman cannot cope in the community and tries to be admitted to an institution that will provide for her. She has learned that state mental hospitals can refuse her but prison cannot. She is currently serving a six month sentence for trying to break *in* to MCI — Framingham. She is housed in the Maximum Security Unit because of her disruptive and bizarre behaviors.

3. This 48 year old woman suffers from schizophrenia of the paranoid type. Psychiatrists have declared her mentally incompetent to stand trial on charges of murder and have stated that she was not mentally responsible at the time of her crime. Nevertheless, she was quickly returned from a state hospital to prison because a judge believed she might present a significant security risk at the state hospital. She has been in the Maximum Security Unit of MCI — Framingham for two years. Because she insisted that she was not mentally ill and refused psychotropic medication, she was not treated for a year and a half, until the Court finally declared her mentally incompetent and appointed a legal guardian who authorized the use of psychotropic medication. Because MCI — Framingham does not have the medical coverage and facilities of a hospital, this woman's treatment has had to proceed at a slow, very cautious pace.

4. This 28 year old woman with a history of chronic schizophrenia and numerous state hospital commitments was admitted to the Awaiting Trial Unit of MCI — Framingham 11 months ago. The Court has not yet decided whether she is competent to stand trial or criminally responsible for setting a fire in her mother's home after her mother allegedly denied the accused access to the home. Because of her active hallucinations, great dependency needs, numerous psychosomatic complaints and tendencies to annoy other inmates, the accused has spent the past 11 months on the Health Services Unit, where she is bothersome to the newly sentenced and physically ill inmates housed there.

5. This 23 year old woman suffers from schizophrenia but refuses to take medication. She has had 11 brief admissions to MCI — Framingham in the past 12 months, repeatedly charged with disorderly conduct and/or prostitution. She is homeless, mentally incapable of holding a job, and will not follow through with appointments at outpatient mental health clinics. She will leave prison again in January 1984.

6. This 57 year old, mentally retarded, epileptic woman spent 35 years at Monson State School and was released when that institution closed. Her mother is in her 80s and cannot care for her. The woman will not stay in a DMH community residence. She was sentenced to one year at MCI — Framingham for shoplifting.

7. This 69 year old chronic alcoholic woman suffers from organic brain damage and mild psychotic symptoms. She has no family or friends and is not able to take care of herself financially or physically, even in matters of personal hygiene. The state hospital will not keep her because she is not immediately dangerous to herself or to others. Nursing home placements have failed because of her drinking. She keeps returning to prison on six-month sentences for disturbing the peace, which she often does right at the police station. When released from prison, she asks policemen and court officers to send her back.

8. This 22 year old woman has been in and out of state hospitals and DMH community residences for several years. She is easily frustrated and either lashes out at others or more commonly, cuts herself with razor blades or glass. She was sentenced to one year at MCI — Framingham after officials at a state hospital pressed charges against her for starting a fire. In prison, this woman often requires physical restraints to prevent her from cutting herself. For the past five months, attempts to integrate her into the general prison population have failed. She is housed in the Health Services Unit but has spent some time in the Maximum Security Unit.

9. This is a 45 year old woman, brain damaged because of abuse she received as a child, who is functionally retarded and illiterate. She was sentenced to prison for three months for breaking glass in a building, something she routinely does to get hospitalized or imprisoned; either way, she is cared for. She cannot function without a great deal of structure. Yet, once in an institution, she is attention seeking and disruptive, destroying property or cutting herself when frustrated or "bored." She cannot get along in the general prison population and requires much supervision, so she is housed in the Maximum Security Unit. The state hospital is reluctant to keep her because she is disruptive and not psychotic.

10. This is a 37 year old delusional woman with a history of several commitments to state mental hospitals, from which she has repeatedly walked off. She has been in and out of MCI — Framingham several times during the past ten years on charges such as trespassing, making annoying telephone calls, calling in a false fire alarm and being a disorderly person. Her current admission to MCI — Framingham was for assaulting a correctional officer while trespassing on prison property. She could not function in the community and wanted to return to prison, where she is "less lonely."

All of the 10 examples were at one time or another cared for by the Department of Mental Health.

Testimony from the president of a board of directors for a vendor doing business with DMH, who also served as chairman of the Mental Health Advisory Board for the South Norfolk Area, pointed to the deinstitutionalization program as a time bomb.

His recommendation was to start over again and attempt to design a system that serves the needs of the patients.

While the suburban mental health patient does not appear to be ending up on the street, he testified that adequate services are no more likely to be provided in the suburbs than in the city.

Community services can be even more difficult to provide within the suburbs because of the greater distances that must be traversed to obtain the service, and the stronger degree of opposition to locating community residences there, by residents.

The vendor president pointed toward the difficulty a deinstitutionalized patient has in traveling to a destination to obtain either mental health or mental retardation services because of the lack of public transportation in the suburbs and lack of funds available for transportation costs. This, at least in part, is created through the department's tendency to write contracts with vendors in metropolitan areas in the same manner it writes them for suburban vendors.

Parents of retarded children at both the Wrentham and Dever State Schools, in testimony before the committee, expressed grave concern that the services, staff, facilities and housing at the state schools could not be duplicated in the community.

The parents, drawing on a lifetime of dealing with the problem on a personal level, pointed toward individual service plans for the severely and profoundly retarded that have been put in place after years of work and question how, with limited resources, the extensive services required by this group could be duplicated in the community.

One parent pointed toward his son who had been a resident of a state school for 25 years. He noted that the boy is brain damaged, retarded, blind and seizure-prone as well as self-abusive.

The parent is convinced that the only approprate setting for his retarded son is the state school.

Another parent whose 28-year-old severely retarded son is at the Dever State School explained how the community-based deinstitutionalization program failed in his case.

After 16 years in the Dever school, the retarded boy was placed in a community home and services provided to him within that setting.

He began to develop a violent behavior which he had never demonstrated while at Dever. The boy, who has a mentality of a 3-year-old, became so violent that the staff at the community home no longer could handle him.

On a Friday night, family members received a phone call alerting them that the staff was going to place the boy in a ambulance and send him to Metropolitan State Hospital.

The parents intervened and after numerous phone calls were able to halt the transfer to Metropolitan and instead have the boy transferred to Dever State School.

The violent behavior, which prohibited the boy's parents from being able to take him home on weekends for 15 months, has since disappeared.

This account raises serious questions of what would have happened to the boy had there been no family to intervene and prevent his being transferred to a mental hospital rather than the state school.

It also raises questions as to what would happen to retarded individuals who are placed in the community and it is later discovered they can not function there, while in the meantime the state schools are entirely phased out, eliminating the back-up system.

FINDINGS AND CONCLUSIONS

The committee finds that while deinstitutionalization has worked in a number of cases, there is a definite growing population of former mental health patients for whom the program has caused severe hardship.

The Department of Mental Health has only itself to blame for the large numbers of former mentally retarded and mentally ill patients ending up on the street, in emergency shelters, hospital emergency wards and in jails and prisons.

The program was embraced too zealously and without first insuring that support and follow-up care was in place.

In order to correct the mushrooming problem at this late date, the committee believes that DMH should attempt to physically locate and interview virtually every patient released through the program to determine how each individual has adjusted.

The department should take into consideration each patient's living quarters, work history and apparent adjustment at the very least, in determining if the patient should continue within the program.

Other factors that should be considered are: criminal records, family perception of progress, and the patient's history of staying in touch with support and follow-up care staff.

The Department of Mental Health should report back to the special committee with its findings and conclusions within one year of this report.

The committee finds that in its effort to deinstitutionalize, DMH has ignored one of its greatest resources in the state hospital and state school grounds and buildings.

The grounds and buildings should be thoroughly evaluated and considered for inclusion in the deinstitutionalization theory rather than considered an alternative to the program.

The committee believes that the state grounds could be used to provide community support services rather than depending on private sources.

A complete assessment of possible utilization of the state grounds to create campus-type settings to house those patients who have not adjusted well to community placement should also be undertaken.

The committee finds that in many cases small homes built on the state grounds which patients could utilize as their residences, yet leave to go into the community to work, would greatly enhance the success rate of returning mentally ill and retarded citizens to as normal a life as possible.

The committee is convinced that the community-based program, while sufficient to treat many individuals, does a poor job of adapting to individual needs.

A campus atmosphere on state hospital grounds would allow for individuals to draw on a larger resource for treatment.

It would afford mental health professionals the ability to continually assess a patient's progress and treatment needs and shift treatment accordingly.

Some patients may need more stringent controls while on the state school or hospital grounds.

Others may need very little and would be free to come and go as they please.

The committee is convinced that use of state grounds in such a manner would improve service to those in need.

It could provide custodial care for those who need it while allowing freedom of movement for others.

For many patients the least restrictive environment they can adapt to is a stringent one in which they must be told when and what to do.

The committee remains convinced that the state has an obligation to continue to provide those individuals with that type of setting and not force them to adopt to the latest theory in treatment.

The committee believes that utilization of the state grounds in this manner would allow DMH to continually monitor a patient's progress, allow substantial freedom and normalcy in life while keeping an important degree of supervision in place.

The committee is fully convinced that such a set-up would drastically reduce the number of patients walking the streets, living in emergency shelters, and ending up in jail cells.

Use of the grounds for respite care centers as well as permanent residences could only enhance the department's control over the program as a whole.

Psychiatry is a limited science and while great advances have been made in recent years, the committee believes there is still a definite need to provide custodial care for many mentally ill and retarded individuals in numbers significantly greater than are currently being cared for.

The committee recommends that the Department of Mental Health report back to the committee within six months with a feasibility study on the use of state hospital and school grounds for campus-type housing and service centers.

The committee believes that DMH has been overly stringent in its interpretation of the commitment law.

The committee believes that an individual need not have to demonstrate a physical attack on himself or another to be considered a danger to himself or to others.

If a disturbed or retarded individual shows no violent behavior, but repeatedly winds up wandering the streets without a place to sleep, that individual is in danger of harming himself in a passive manner.

The committee believes that a broader interpretation of the commitment law would only result in patients being better served in a more structured treatment program.

SPECIAL RECOMMENDATIONS

The committee is greatly concerned with the danger to former patients who end up in older, more fire-prone buildings, and believes that the fire code and the protection it offers needs to be reworked.

The committee will sponsor legislation to change the fire code and generate a greater degree of protection through prevention.